Does Family Presence in the Trauma Bay Help or Hinder Care? Benny L. Joyner, Jr., MD, MPH

Abstract

Family presence during a pediatric resuscitation remains somewhat controversial. Opponents express concern that family presence would be detrimental to team performance and that exposure to such a traumatic event could put family members at risk of posttraumatic stress. Proponents argue that family presence affords families a sense of closure by easing their anxieties and assuring them that everything was done for their loved ones in addition to improving clinicians' professional behavior by humanizing the patient. This article will review the literature on the potential benefits and pitfalls of family presence during a pediatric resuscitation.

Overview of Questions about Family Presence in a Trauma Bay

Few events in a physician's life are as emotionally charged as the arrival of a pediatric patient in a trauma bay. A previously healthy child arrives with a life-threatening or life-limiting injury after a catastrophic event with family members in tow, distraught and devastated. The clinical team mobilizes to stabilize the patient—triaging and evaluating injuries, performing invasive procedures, and providing life-saving therapies. In many instances, the family is held outside the trauma bay. Should the family be permitted to enter? This question remains a subject of significant controversy, as evidenced by the fact that while studies suggest benefits of family presence, the practice varies widely [1-3]. According to Nibert, a "moral conflict exists because two opposing obligations collide: an obligation to the family members who desire to be present with their loved one during CPR and an obligation to the healthcare providers who do not want patients' family members to witness resuscitation efforts" [4].

What obligations do we owe our patients with respect to allowing their family members to be present during a resuscitation? Are we acting in the patient's best interest by keeping family members away during a resuscitation? Are we truly preventing harm, alleviating suffering, and being just when we keep family members out of the trauma bay? The answers to these questions are complex and strike at the heart of the nexus between patients' rights and clinicians' rights and obligations.

The Debate over Family Presence

Family presence during resuscitation (FPDR) can be defined as "the presence of family in the patient care area, in a location that affords visual or physical contact with the patient during resuscitation events" [5]. The controversy surrounding FPDR first emerged in the literature in the early 1980s when a hospital in Mississippi described a situation in which two family members demanded to be present during the resuscitation of their loved ones [6]. Studies of FPDR have shown that family members and staff who were involved in resuscitations report positive attitudes about the practice [1-3, 7-9]. In one study, the majority of family members reported being able to understand the therapeutic interventions performed, to advocate for their child, and to calm or reassure their child during such an event [1]. Families also believe that FPDR is a parental right [1, 8], and clinicians believe that it can help both the medical team and families whose child dies [2]. Moreover, some studies suggest that FPDR does not negatively impact clinical performance or resuscitation efforts [9-12].

Despite these findings, FPDR remains a controversial topic [9, 13]. A prominent argument is that parental presence during pediatric resuscitations should not be permitted because it is not in the child's best interest. Parents might misunderstand treatments provided to their child, which could create a stressful environment for staff and contribute to rather than relieve patient anxiety [2]. Moreover, task performance of inexperienced staff or physicians participating in the resuscitation might be negatively impacted by parental presence [2]. Additionally, clinicians have argued that it should be up to them—not families—to determine in which situations family presence ought to be granted [14, 15]. Finally, those opposing FPDR could rightfully argue that the data upon which these conclusions are drawn are scant, as many surveys have poor response rates [8].

Because patients, family members, and clinicians can have different perspectives on whether FPDR helps or hinders trauma care, the four ethical principles described by Beauchamp and Childress—respect for autonomy, nonmaleficence, beneficence, and justice [16]—will be used here to evaluate FPDR from each of these stakeholder perspectives.

Patient Perspective

From the patient's perspective, the safe, efficient, equitable, compassionate, and effective delivery of care is of paramount importance. Pediatric trauma patients—arguably the most vulnerable because they are unable to advocate for themselves—must rely on clinicians acting in their best interest and on proxies (usually their parents) speaking on their behalf. Because of the lack of data on pediatric patients' perspectives, studies of family presence during pediatric resuscitation invoke the principles of respect for autonomy, beneficence, nonmaleficence, and justice to support their arguments [13-15].

Beneficence. Those supporting FPDR argue that it can benefit the patient, as it enables parents to provide pediatric patients with emotional support during a traumatic and emotionally frightening procedure and clinicians with important, timely, and relevant medical information to assist the resuscitation team in their efforts [1, 8, 14]. One prospective study demonstrated that family presence does not prolong time to computed tomographic (CT) imaging or resuscitation completion for pediatric trauma patients [10]. Another study demonstrated that FPDR does not negatively impact the performance of advanced trauma life support tasks [11]. Given the positive psychological impacts and lack of negative clinical impacts, one could argue for an overall net positive impact of family presence for the patient. However, opponents of FPDR voice the concern that parental anxiety and emotion might contribute to the anxiety of the distressed and ill child, further complicating treatment management [14, 15]. They thus tacitly invoke the principle of beneficence in arguing that removal of the parents removes the potential for harm to the patient.

Nonmaleficence. Those in support of FPDR also argue that not allowing family members to be present would prevent necessary information from being delivered to a patient's caregiving team, delay necessary consents, and leave a pediatric patient unsupported during a chaotic trauma resuscitation [12, 13], delaying care and causing additional physical or psychological harm or injury.

Justice. The principle of justice requires that we treat all patients fairly and equally, but families are not universally allowed or invited to be present during a trauma resuscitation. Do we allow those who are the most vocal to be present, thereby allowing only certain patients to experience the benefits of FPDR? However, if a family member is excluded from participation by medical staff due to inconsolability or emotional outbursts, are we not depriving that family member's child of the same opportunity as another child simply due to a family member's understandable grief? One approach to rectifying this inequity would be the adoption of an institution-wide policy of family presence during pediatric resuscitation, which has been shown to have no adverse effects on patient care [12].

Family Perspective

Beneficence. Parents view positively having a first-hand account of events and serving as their child's advocate and comforter [1]. Families also believe they have the right to be present during these intimate and personal events [1, 8] and that being present can be therapeutic and provide reassurance that everything that could have been done, was done [2, 13]. Some could argue that since family presence would be primarily for the potential benefit of the family member and not the patient, family presence should not be permitted and could indeed hinder the resuscitation of the pediatric patient. However, as discussed above, FPDR allows family members to provide information that could

facilitate decision making, and it eliminates the need for explanation of services being provided [1, 8]. In this sense, FPDR also upholds the principle of respect for family autonomy.

Respect for autonomy. An important caveat is that FPDR must be allowed in a way that ensures that families are supported and informed. In most situations, this is achieved through a family support facilitator [1, 3, 9, 13], because family presence during a trauma resuscitation absent the context with which to frame such efforts can be detrimental to the family present [1, 9, 12].

Nonmaleficence. By forbidding FPDR, are clinicians inadvertently causing long-term harm to families, as families that were not present report heightened feelings of anxiety and posttraumatic stress [17]? Indeed, we could even (inadvertently) be causing harm to families that realize only too late that were it not for their fear of challenging the health care team, they could have been present for their child's resuscitation.

Treatment Team Perspective

Beneficence. The principle of beneficence and, in particular, the patient's best interest, is often invoked to explain clinicians' arguments both supporting and opposing FPDR [14]. When used to oppose FPDR, however, this rationale is problematic because the concept of a patient's best interest not only is subjective but also is often inconsistently applied [14]. In addition, the view that FPDR is not in the patient's best interest is not supported by the literature, as parents who have been present during resuscitations have reported decreased anxiety, a better understanding of their child's condition, and a desire to be present again during their child's medical care [1, 6-8, 10, 12]. Nevertheless, clinician attitudes and beliefs about FPDR still remain a source of contention [7].

Nonmaleficence. Clinicians opposed to FPDR argue that it would have a negative impact on the treating team and its ability to provide appropriate care [2, 7]. Pediatric trauma resuscitations are often chaotic, requiring many invasive procedures, and, on occasion, the inevitable outcome is the death of a patient. Given these factors, emotions often run high and clinical staff fear that the added stress of family presence would negatively impact the resuscitation and lead to worse outcomes [2, 7, 18]. Although this perspective is supported by anecdotes and case reports, negative impacts are not borne out in studies of family presence during pediatric trauma resuscitations [6, 7, 9-11]. Finally, although a simulation study demonstrated a delay in time to first shock during a simulated adult medical code as evidence that care could be delayed [19], this finding has not been validated in other studies in the pediatric setting [8].

Ethical Grounds of FDPR Permissibility

The various impacts of FPDR can be analyzed using a structured, principled approach. Although it is an extremely complex issue with many potential impacts on the patient,

family, and trauma team, FPDR is ethically permissible given its significant potential benefits (and minimal risk) for pediatric patients and their families. For this reason, a more structured global approach to this topic should be undertaken to address the inequities that currently exist in our system—a system in which family presence in the trauma bay is dependent upon geography and level of advocacy.

References

1. O'Connell K, Fritzeen J, Guzzetta CE, et al. Family presence during trauma resuscitation: family members' attitudes, behaviors, and experiences. *Am J Crit Care*. 2017;26(3):229-239.
2. Dingeman RS, Mitchell EA, Meyer EC, Curley MA. Parent presence during complex invasive procedures and cardiopulmonary resuscitation: a systematic review of the literature. *Pediatrics.* 2007;120(4):842-854.
3. Curley MA, Meyer EC, Scoppettuolo LA, et al. Parent presence during invasive procedures and resuscitation: evaluating a clinical practice change. *Am J Respir Crit Care Med.* 2012;186(11):1133-1139.
4. Nibert AT. Teaching clinical ethics using a case study: family presence during cardiopulmonary resuscitation. *Crit Care Nurse*. 2005;25(1):39.
5. Clark AP, Aldridge MD, Guzzetta CE, et al. Family presence during cardiopulmonary resuscitation. *Crit Care Nurs Clin North Am*. 2005;17(1):24.
6. Hanson C, Strawser D. Family presence during cardiopulmonary resuscitation: Foote Hospital emergency department's nine-year perspective. *J Emerg Nurs*. 1992;18(2):104-106.
7. Vincent C, Lederman Z. Family presence during resuscitation: extending ethical norms from paediatrics to adults. *J Med Ethics*. 2017;43(10):676-678.
8. McAlvin SS, Carew-Lyons A. Family presence during resuscitation and invasive procedures in pediatric critical care: a systematic review. *Am J Crit Care.* 2014;23(6):477-485.
9. Kingsnorth J, O'Connell K, Guzzetta CE, et al. Family presence during trauma activations and medical resuscitations in a pediatric emergency department: an evidence-based practice project. *J Emerg Nurs*. 2010;36(2):115-121.
10. Dudley NC, Hansen KW, Furnival RA, Donaldson AE, Van Wagenen KL, Scaife ER. The effect of family presence on the efficiency of pediatric trauma resuscitations. *Ann Emerg Med*. 2009;53(6):777-784.e3.
11. O'Connell KJ, Carter EA, Fritzeen JL, Waterhouse LJ, Burd RS. Effect of family presence on advanced trauma life support task performance during pediatric trauma team evaluation [published online ahead of print May 8, 2017]. *Pediatr Emerg Care*.
12. O'Connell KJ, Farah MM, Spandorfer P, Zorc JJ. Family presence during pediatric trauma team activation: an assessment of a structured program. *Pediatrics*. 2007;120(3):e565-e574.

13. Mangurten J, Scott SH, Guzzetta CE, et al. Effects of family presence during resuscitation and invasive procedures in a pediatric emergency department. *J Emerg Nurs*. 2006;32(3):225-233.
14. Giles T, de Lacey S, Muir-Cochrane E. How do clinicians practise the principles of beneficence when deciding to allow or deny family presence during resuscitation? *J Clin Nurs*. 2018;27(5-6):e1214-e1224.
15. Lederman Z, Garasic M, Piperberg M. Family presence during cardiopulmonary resuscitation: who should decide? *J Med Ethics*. 2014;40(5):315-319.
16. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. 7th ed. New York, NY: Oxford University Press; 2013.
17. Robinson SM, Mackenzie-Ross S, Campbell Hewson GL, Egleston CV, Prevost AT. Psychological effect of witnessed resuscitation on bereaved relatives. *Lancet*. 1998;352(9128):614-617.
18. Vavarouta A, Xanthos T, Papadimitriou L, Kouskouni E, Iacovidou N. Family presence during resuscitation and invasive procedures: physicians' and nurses' attitudes working in pediatric departments in Greece. *Resuscitation*. 2011;82(6):713-716.
19. Fernandez R, Compton S, Jones KA, Velilla MA. The presence of a family witness impacts physician performance during simulated medical codes. *Crit Care Med*. 2009;37(6):1956-1960.

Benny L. Joyner, Jr., MD, MPH, is an associate professor of pediatrics, anesthesiology, and social medicine and a pediatric intensivist at the University of North Carolina (UNC) at Chapel Hill. He currently serves as the chief of the Division of Pediatric Critical Care Medicine and vice chair for hospital inpatient services and is also one of the lead ethics consultants on the UNC Medical Center Hospital Ethics Committee.